SOCIAL CONVICTIONS AND CLINICAL PSYCHIATRY*

GREGORY ZILBOORG

Clinical Associate Professor of Psychiatry, State University of New York College of Medicine at New York City

THE doctor today, regardless of some of his personal and professional failings which may be both conspicuous and numerous, still remains the symbol of self-sacrifice and devotion to duty. Neither the public nor the medical profession seems to be easily dissuaded from the lingering conviction that the doctor may not refuse to treat an ailing person merely because the person is too poor or the doctor is too tired. In the mind of the man in the street the doctor should not be too poor, but neither should he be rich, because if he shows any degree of affluence he may be suspected of exploiting his patients. The doctor may never be tired, nor sleep too much, and he should always be ready to "take a call."

There are other unspoken demands made upon the doctor. He must not spend too much time with his own wife and family, although he ought always to be charitably ready to take profound interest in the wife, husband and children of other families. The doctor should not be a politician; a doctor who takes active part in politics is looked upon with the same suspicion which is accorded to a priest who enjoys social entertainments.

We know that in fact all these demands are not strictly imposed or strictly respected. We have had medical doctors who were politicians enough to be elected to the United States Senate, and we have had and have doctors whose social life is far from interfering with their professional reputation. Yet the demands exist, and they make themselves felt every now and then. The Hippocratic Oath is still looked upon not only as an oath of office but more as an act of self-dedication and consecration. This attitude of both the public and the doctor, no matter how couched in the present-day idiom of automobiles, typewriters and politics, is a sign of how deeply rooted within us is the tradition that medicine originated in priesthood. No matter how modern and sophisticated we may appear, there lives within us a mixture of

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prejudice and jealous faith which reflects some of the old demands of the days of Hippocrates nearly twenty-five centuries ago, of the days of Rhazes nearly one thousand years ago, demands that a physician remain a physician and indulge in no drink, or music or poetry.

Ours being a practical age, we would be a little astonished if a physician refused a cocktail on the grounds of professional ethics, and we vouchsafe the poetry of an Oliver Wendell Holmes and the novels of a Weir Mitchell. Yet the fantasy of spiritual perfection perseveres in our image of a physician. This does not mean necessarily that we consciously and always idealize our doctors and imagine them perfect. On the contrary, we are prone as often as not to criticize them for their failings, which criticism is often but an expression of an ideal betrayed, or an idealization deceived. This is particularly true of the general attitude toward the psychiatrist. We resent in him anything which appears to us neurotic. A psychiatrist is not supposed to be "subjective" or low spirited, or too enthusiastic. If we condense all those things which a psychiatrist ought and ought not to be, we shall obtain an image of an Olympian middle-of-the-roader, a generous, outgoing, yet great, silent man, a person who feels deeply everything for everybody and has no deep feeling for anything. A paradoxical image, of course; age-long fantasies are always paradoxical and inconsistent with truth. But history knows a few medical figures who were of truly heroic proportions and who yet remained inconspicuously detached, happily or luckily little and quiet as compared with the vastness and noisiness of the events around them. Philippe Pinel was such a person. He lived through the bloodiest days of the French Revolution, the militaristic rise and fall of Napoleon, the pomposity of the Restoration. Yet he remained a doctor to his patients, a citizen who fought the prejudices of the Jacobins against the mentally sick; he wrote steadily, and continued his work of organization. He warded off the imperial distinction which Napoleon offered him, and escaped the decorous recognition with which he was threatened by the advent of Louis XVIII. To be sure, Pinel was unique. He was an exception of the first order. The average doctors of his day must have fared less well, and certainly most of them must have been engulfed in the social and political struggles of their day.

One need not, especially in our industrial civilization, wait for some severe social crisis to see how the physician, particularly the psychiatrist, becomes involved in the issues which are pointed up by the given

crisis. But it so happens that the twentieth century has been one of successive crises which in our generation have reached global dimensions, and we can no longer indulge in our old fantasy of Olympian objectivity and equanimity. For in general medicine and surgery there are still stretches of activity which are characterized by what Oliver Wendell Holmes called Medical Christianity. The surgeon, for instance, cares little whether a given gallbladder duly filled with stones and duly infected belongs to a murderer, a justice of the Supreme Court, or a Communist official. The gallbladder must be removed, and the surgeon removes it. Who would think of blaming or approving of such a surgeon, of speaking of him as a person who aids and abets crime, or serves the ends of justice, or favors Communism? Moreover, the surgeon himself would hardly feel guilty for having performed a cholecystectomy on a criminal, nor would he feel particularly virtuous for having taken out the appendix of a judge, nor would he consider himself a fellow traveler whose conscience is tainted with pink because he operated on a Communist official.

The psychiatrist finds himself in a different and singular situation. Not only do district attorneys and judges and juries suspect him of being strange and not a little anti-social when he testifies to save a murderer's life; the psychiatrist himself feels not a little squeamish if he says something about the mental condition of the defendant which might ease the defendant's fate. He feels as if he sides with the criminal and therefore in part condones the crime. All this may not be crystallized and precise in the psychiatrist's mind, but his usual discomfort in such situations means just this. I do not know whether the psychiatrist would feel particularly virtuous in treating a jurist, but there is no doubt that he would feel troubled, and quite deeply, if he were called upon to treat a Nazi or a Communist. As to the "world," if "they" knew that he had a well known Communist or Nazi as a patient, they would wonder "how he does it."

In other words, the psychiatrist constantly finds himself in the very midst of those conflicts above which he himself cannot easily if at all rise, and beyond which he is hardly able to reach out without settling in his own mind a number of issues—social, political and religious. All this creates a number of complex and confusing problems both for the psychiatrist and for his patient, and particularly of course in times of great cultural crises.

Take as an example the situation in the Soviet Union. To be sure, any citizen of the Soviet Union is required by the very nature of the totalitarian state to assert his loyalty to the prevailing ideology and to accept the basic tenets of the social philosophy of the Soviet State. Yet the surgeon or the internist is not called upon to explain the use of certain sutures, or the physiology of diabetes, in terms of economic determinism. The psychiatrist, on the other hand, finds himself enmeshed in the cobwebs of the prevailing social philosophy. Thus an old colleague of Charcot, a great neurologist and a general in the Tsar's Army Medical Corps, the master-neuroanatomist and neurophysiologist V. M. Bechterev sought in his old age to give point to his theory of conditioned reflexes by pronouncing this theory to be well adapted to the Hegelian-Marxian dialectic materialistic philosophy. Consciousness, its very existence, has been loudly and emphatically denied. In this denial the Marxian materialists unbeknown to themselves became metaphysicians by calling consciousness merely a "higher form of the organization of matter."

It is very difficult under these psycho-social circumstances to be an objective clinical psychiatrist. For in addition to the social philosophy which appears to have become both a peremptory and mandatory part of psychiatry, the psychiatrist is impeded clinically by the necessity of observing only those symptoms which would serve to corroborate that philosophy, or to refute the opponents of it. Psychoanalysis is rejected not because its empirical findings are tested and found incorrect, but because those findings are judged in advance as non-acceptable since Freud is considered a metaphysician, an idealist and individualist—all designations of scientific and even moral opprobrium, because only the practical materialist and socialist are supposed to be endowed with the gift of begetting the truth. Clinical psychiatry under these circumstances regresses to that historical level at which it was some four hundred years ago, when it just began to try to become a true branch of clinical medicine. This was the level at which the established order of things refused psychiatry the right to become scientifically independent; it insisted that psychiatry remain inseparably fused with the religious philosophy and social prejudices of the times.

I am not unaware of course that the type of retrogression of which I speak here is not absolute. A great many scientific works are being pursued in the Soviet Union today, but the principle of having a social

philosophy officially dominate a branch of clinical medicine is a deadening principle whichever way you may look at it.

However, this process of retrogression of clinical psychiatry is not limited to the Soviet Union. In the Soviet Union today this retrogression is apparently imposed by the policy of the state from without, as it were. In other countries, and even in ours, psychiatry shows some similarly discouraging signs–and the pressure seems to be coming from within, with no interference on the part of the state. Let me cite to you a short excerpt from a recent issue of a medical journal. "Most people," state the psychiatrists who contributed this article, "do not realize that competition is a biological characteristic fundamental to the behavior of mankind. This blindness to reality seems to perpetuate socialism and communism. . . . The refutation of the concept of psychopathic personality by psychoanalysts and by communists, and the denial of the Mendelian Law by Lysenko is evidence that our culture is now standing upon an interesting threshold–who knows? Maybe the Dark Ages are again upon us." . . . And further: "There is a communistic, a psychoanalytic and a socialistic contention that a properly controlled environment would have changed the outcome of anti-social children. This contention supposedly justifies a deluge of social workers to take care of family problems. Once again we hear the accusation, 'You don't love our children or society enough,' you must share your possessions to prove this love and affection.

"Such is reflected today as the greatest problem of our American democracy; Social Security, unemployment compensation, and old age pensions are manifestations of a social psychopathy."[1]

It is granted that the above is a very extreme expression of a very extreme opinion in a manner of quite extreme confusion. Yet even after we make all these allowances, we shall admit that this opinion in some way reflects a psychological trend in present-day psychiatry which may not be overlooked or underestimated. For under the influence of the present-day critical events of political, social and spiritual tensions, two things in the field of psychiatry have become especially accentuated.

1. Not only is the psychiatrist called upon to use his skill in the treatment of the victims of our conflicts wherever they are found, in the army, in industry, in our society in general, but also he is asked to use his skill in direct participation in defense efforts, in psychological

1 Coyne H. Campbell, Harold G. Sleeper, "Socialism and Psychopathy." *The Journal of the Oklahoma State Medical Association*, Vol. 45, No. 4, April 1952, p. 138.

warfare. In other words, the psychiatrist is called upon to become a combatant possessing special medico-psychological skill, rather than to remain merely a doctor whose job is to care for the sick.

2. The psychiatrist is called upon, or as a result of cultural pressures he volunteers, to use his clinical knowledge in order to preserve or to salvage various concepts of social values which seem to be threatened by the ever-mounting crisis. The psychiatrist then seeks to transpose his psychiatric clinical concepts into social ones; these efforts are impressive in their daring but highly confusing as to practical results or scientific validity. Thus it has come to pass that, depending upon the camp he happens to be in, the psychiatrist will "recognize" the psychopathic and communistic traits in psychoanalysts, or he will dub the communist or the fascist a psychopath and claim to have discovered a well-defined, anti-Semitic or authoritarian personality.

What happens in this confusion is this: the clinical psychiatrist, as a result of the mounting of his own awareness as a citizen, as a child of his age, as a son of his country, as a defender of democracy, becomes engulfed in the maelstrom of social passions and recognizes as the true sons of democracy only mature, adult, non-neurotic individuals. He is apt to assert that the non-democratic individuals—the Communists, the Fascists, the Nazis—are all immature, infantile, neurotic, psychopathic individuals. Thus, clinical psychiatric terminology becomes little more than bitter namecalling in the midst of social passion and prejudice—a far cry from the objective, clinical, humanistic Medical Christianity which was so much extolled by Oliver Wendell Holmes.

I would not want to give the impression that the clinical psychiatrist can or must be completely outside the social struggle and shun any of the issues which confront us today. But I do want to say, and as emphatically as I am able to, that the psychiatrist who aids and abets the cure of society of its alleged social psychopathies becomes more a slave of the ideology he happens to accept (from Jefferson to Marx), and must therefore sacrifice both his scientific objectivity and his medical humanism. To be aware of the nature and intensity of the cultural struggle around us, to be a part of it, is one thing; but to be an active servant and partisan of this struggle is another thing—it is something that has really nothing to do with the curative art.

What is the psychiatrist to do? It is not easy to give too definite an answer. I, for one, found it impossible on some occasions to treat a

sincere Nazi sympathizer in the midst of Hitler's terror. I had to interrupt the treatment because I was unable to control my sense of revolt and revulsion. Now, when the psychological distance from Nazism has been established, I would not find it difficult to treat an anti-Semite or Nazi. The same I found to be true with some convinced adherents of Communist political philosophy. In general I found it not difficult to treat certain patients of fascist or communist leanings whose neurosis was colored by their social philosophy, but I did find it difficult and most of the time impossible to be confronted with a rigid social philosophy, well crystallized as if independent of the neurosis itself. I believe that the psychiatrist ought to be able to assess his own social susceptibility and prejudices without shame and without self-righteousness, and proceed with his therapeutic task in those cases in which he can in his own eyes preserve his own psycho-social integrity. Often it is difficult to assess our susceptibilities and prejudices, particularly in times of crises during which psychiatrists cannot help but be directly or vicariously involved. Yet an assessment of one's own psycho-social inventory, difficult and imperfect as it often may be, cannot help but preserve the medical tradition of psychiatry. Any other form of squaring ourselves with the problem thus far offered does injury to psychological medicine and to the professional integrity of the psychiatrist.

One of the suggestions for solving the difficulty is that we wear quite honestly and candidly the mask of supreme objectivity—as if nothing really disturbs us, nothing that anyone may do or fail to do. This mask is frequently imposed upon us by the public who picture the psychiatrist as an immovable rock of wisdom and detachment. True, the collective tongue of the public is always in its collective cheek when it raises psychiatrists to these non-existent heights of objectivity. Yet both the public and psychiatrists are apt to become seduced by this type of fantasy and behave as if it could be a reality.

Another way to escape the difficulty, recently suggested in some quarters, is for the psychiatrist to refuse completely to participate in any controversial social and political undertakings. It is suggested that the psychiatrist walk alone, so to speak, in a sort of movable ivory tower of splendid isolation, away from yet in the midst of the world. Such a self-imposed cleaving away from the main stream of life is to say the least impractical. But it is also very dangerous, because if successful it would remove the psychiatrist from the human contacts without

which he cannot be a psychiatrist, and if a failure, it would force the psychiatrist into an atmosphere he does not approve. He would then be resentful and therefore unable to be a psychiatrist; for one cannot be a psychiatrist while carrying a sense of resentment, any more than one can be a surgeon while suffering from a blood phobia.

The above outline of the difficulties with which the psychiatrist is confronted today might give the impression that there is no solution, no adequate alternative to be found. To some extent this is true. As long as the cultural crisis is acute, it is impossible to prescribe any sure cure. There will always be Pinels, Esquirols, and Isaac Rays—men who can somewhat rise above and yet remain a part of human struggle. But there will always be the majority of us who become a part of the failings and failures of our age, like a Jean Fernel or a Felix Platter. These men were great clinicians and master medical minds but unable to rid themselves of the prejudices of their day. They hated witches and sorcerers. Fernel refused to give medical aid to suffering alleged witches; Platter would study the mentally ill with miraculous tenacity and apparent objectivity, but he was unable to consider that their place was in a hospital because their illness he believed was of the devil. The history of medicine, and particularly the history of psychiatry, knows many examples of such failures, for they were numerous, and at times they were the majority of the medical profession. But in the end it was a Johannes Weyer who won the day and brought psychiatry to the clinical and curative level to which it had for so long struggled to rise. In other words, the failures, no matter how numerous they may be, are after all but as much a sign of the times as the cultural crises themselves.

In the light of this historical perspective one must admit that psychiatry just now is going through a period of not inconsiderable flux because it is so often engulfed by the crises of our day. That which is most important in psychiatry and to the practicing psychiatrist—the human individual, the person, the integrated human being—seems to be overshadowed by more pressing things. The advent of social cures, electric shock, operative procedures are but a reflection of the "total push" of our time in the direction of mass action, mass behavior, mass drives, mass production and mass integration. Clinical psychiatry cannot escape this tidal wave in the Western cultures any more than in the Soviet Union. However, should a Johannes Weyer arise in our Western culture—and he would probably have a very difficult time as Weyer

himself had—he would still have his chances to survive, even as Johannes Weyer and his work succeeded in surviving despite the fact that he lived in a dangerous age of bonfires and ruthless scorn for certain truths. For as long as there is, be it ever so formalistic, the recognition of the value of the individual in man, man cannot be lost. And as long as the value of the individual is preserved, clinical psychiatry will not only survive but may be the only clinical scientific discipline which will make a decisive contribution to the solution of the present-day crisis.

This is why the psychiatric clinician today, whatever his social bent, finds himself more and more called upon to solve the problems of the relationship between psychiatry and moral and religious values. Those psychiatrists who are engulfed by the mass mentality of today do not seem to seek for a solution of this problem. In fact, they deny the need of introducing moral and religious values into the scope of their clinical perspectives. These psychiatrists make their own contribution to the solution of the problem in that they point up the acuteness of our cultural crisis by succumbing to sociological, mass therapeutic trends. They, by the very virtue of the stand they take, will deal with statistics and common denominators. In other words, they will of necessity seek that which was decried by Oliver Wendell Holmes as early as the mid-sixties of the last century, when he exhorted young medical men to avoid becoming fascinated by the vogues of averages. The average, the disindividualized common denominator, is an important factor in the impersonal disindividualized world of crises in which we live. At the same time, this very rise in importance of the common denominator contains the seeds of the fall of this method of approach, since the common denominator is derived from masses of men, and man cannot survive except as a self-conscious, autonomous individual.

There is no doubt that we are now going through a period of disindividualizing our lives, and therefore we are not yet able to develop fully a true, humanistic clinical psychiatry. But then, historical perspectives do not appear to visualize the human world as functioning like a human ant-hill. The statistical, common denominator method is self-limited, whereas the individual as the unique and only bearer of human life and its values will sooner or later assert his autonomy and his importance regardless of the stifling low level to which he is pushed by our critical times. And with the renewed rise of the individual, the renaissance of humanistic psychiatry will become inevitable.